

**Clinical Quality Workgroup
Characteristics of Optimal Clinical Quality
for Health IT Tiger Team
Draft Transcript
April 30, 2012**

Roll Call

MacKenzie Robertson – Office of the National Coordinator

Good morning everyone, this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Standards Committee, the Clinical Quality Workgroup Characteristics of Optimal Clinical Quality Measures for Health IT Tiger Team. This is a public call and there will be time for public comment at the end. The call is also being transcribed so if you could please be sure to identify yourself before speaking. I'll now go through the roll call. Karen Kmetik?

Karen Kmetik – American Medical Association

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Karen. Anne Castro?

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Anne. John Derr? Bob Dolin? Rosemary Kennedy? David Lansky? Robert McClure?

Robert McClure – Chief Medical Officer - Apelon, Inc.

I'm present.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Robert. Eva Powell?

Eva Powell – National Partnership for Women & Families

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks. Eric Rose?

Eric Rose – Intelligent Medical Objects

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Eric. Danny Rosenthal, I know is unavailable. Randy Woodward? Patrice Holtz? Kim Schwartz? Jon White? And if there are any staff on the line if they could please identify themselves?

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

Jacob Reider, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jacob. Okay, Karen I'll turn it over to you.

Karen Kmetik – American Medical Association

Thanks, MacKenzie, good morning everyone, thanks for making the time again to talk. As you'll see on the second slide I'm suggesting that today we focus our time on outcome measures, clinical outcome and patient reported outcomes. We've received a lot of rich information from you on the past calls which we're putting together in the form of recommendations, but I don't think we talked significantly about these two types of measures. We talked about process measures, delta measures and we went through the different criteria we have, the technical lens, but I would welcome getting some conversation going today about those two types of measures then the plan would be to put this all in a document of our summary recommendations, get that out to you Friday and give you a week to respond among all of us by e-mail.

Again, apologies for very late notice of today's agenda, but I think if we have a conversation today on those two areas we have enough to put something to paper for you to react to with a little more timeframe. As long as we get our recommendations to ONC by the end of May we are in good form. Any questions on that?

Okay, I'd like to get reactions to thinking about outcome measures, let's start with what we might call clinical outcome measures and just to refresh everyone's memory I know it's been a while and we're so busy, we've been looking at these things through both a technical lens and a workflow lens and we've been thinking about, well what would we want to see, know, learn from analysis testing, implementation early on to feel like this measure is ready to be incorporated into government programs that use data from EHRs.

So, just again, to refresh our memories, we talked about usability, we talked about that definition meaning things like the data are available, it can be captured in traditional workflow or with reasonable workflow changes. Also, under usability we talked about data capture not being redundant unless we purposefully wanted it to be redundant for example with some clinical decision support tools.

When we talked about feasibility we were thinking about the functionality to support the measure. We decided to not worry about EHR sensitives. When we talked about accuracy we would have conversations about, well maybe the data can be captured, but we all know it's not exactly accurate and should we be paying attention to that when we get information back from feasibility, implementation, preliminary analysis.

And then we spent time talking about standard terminology making sure that the standards for terminology are available that would support the measure and how important is that to learn when we go through the exercise of putting the measures through the technical lens before they are actually integrated into a program. There is much more we've talked about, but just wanted to review those broad definitions.

So, if I could then, this is slide 3 if you have it, and let's not worry too much about required for 2016 or not required for 2014, but more generally to think about if we have an outcome measure now a different kind of process or a delta measure of perhaps and intermediate value, but this is more of an outcome, you might think of re-admissions, you might think of avoiding a complication. Do we need to think any differently about the criteria? So, a simple example we tee'd up here is just if you think about usability, usability meaning the availability of the data, obviously if we're looking at an outcome that occurs in time is the EHR tracking that patient population over time such that the information would be there for a defined population?

Feasibility, you know, what functionality requirements would we need? Is there anything unique there if we're talking about outcome measures, particularly if we're talking about an outcome being the avoidance of something? Accuracy, what comes to my mind of course, do we have everything we need for a proper risk adjustment including an algorithm that is going to be applied? And then are there any issues on terminology? And then we'll talk about the same for patient reported outcomes, but I'd be curious if anybody has a reaction to things we might think about differently here?

Eric Rose – Intelligent Medical Objects

This is Eric Rose; at first blush I'm challenged to think of anything in terms of the requirements for outcome measures that would be different from requirements for process measures, I mean of course outcome measures are kind of a very delicate issue in that one wants to set outcome measures...frame them in such a way that they really reflect something that is under the control of whoever is being measured so you're not essentially holding people accountable for things they can't control, but that's really different from what the Tiger Team is looking at, I mean, so that would be a question of sort the contents of the measure, which is out of the scope of our inquiry.

As far as the technical aspects of the measure I can't...it doesn't seem to me that there is a different set of desiderata or outcome versus process measures unless there is a nuance that anyone else can think of that I'm overlooking.

Eva Powell – National Partnership for Women & Families

This is Eva and I don't know if this fits in this conversation in terms of adding in essence a separate column, but I think the critical difference between a process and the outcome is exactly what I think, was it Eric that was speaking, what he just said in the sense that outcomes are a result of a number of different things many of which are controllable by the provider, but also there are other factors involved as well obviously and if we through Meaningful Use have decided that patient engagement is not just a nice thing to do, but it's actually essential to better outcomes, I'm just wondering what is the connection between the outcome measure and the patient reported outcome?

In other words, was is the patient component of the outcome measure and I think that's the tie between or perhaps the patient reported outcome is a tie to the clinical outcome and I'm not sure I'm making any sense, but I guess what I'm saying is say you've got a patient who has a goal of being able to walk, you know, "x" number of feet and that's a very practical goal for them, they can work on that themselves, they can see progress, but that's not really a clinical goal, but there certainly are things for a clinician who knows that that's the patient's goal, knows he or she needs to get to clinically in order for that to be likely to happen.

And so, to me that's where those two things work together and I don't know if maybe this will occur naturally and we will learn these things as we incorporate both clinical and patient outcomes or if we need to be a little more intentional about this by trying to identify maybe pairs of patient outcomes and clinical outcomes, I don't know that that really makes sense, but, am I making any sense in this whatsoever? I just see that there is a very clear tie, although I don't know that the nature of that tie is clear at this point.

Karen Kmetik – American Medical Association

Eva, this is Karen, what I'm thinking of when you're saying that is we might have a measure that is really important called mutually agreed to care goals.

Eva Powell – National Partnership for Women & Families

Right.

Karen Kmetik – American Medical Association

And maybe that's not really an outcome measure, it's not really a patient reported outcome measure, but that's a measure that would say the patient and physician teams have agreed, these are among the goals for this particular perhaps episode of care and then that's a unique measure almost to which the clinical outcome, the patient reported outcome, related process measures, I mean they all contribute to whether that agreed upon care goal is met. I don't know if that helps?

Eva Powell – National Partnership for Women & Families

Yeah, yeah and I think that's actually a good...and I'm maybe taking us a little off track here, so I won't belabor this point, but when we try to think about care coordination measures and how do we measure that, to me ultimately if we're going to kind of stick to this notion of let's focus on outcomes then the outcome of care coordination is coordinated care which can be demonstrated by goals that are met, assuming you've made logical and reasonable and worthy goals.

So, that might be something to pursue in terms of kind of tying all of this to the process and progress of a care plan, but anyway I'll stop there, because I think that's kind of getting us a little off track, but I just wanted to point that out, that I think there's a really critical tie, again if you're assuming that patient engagement is critical to outcomes and not just a nice thing to do, which I think is kind of why we're all talking about this that there really is or must be some sort of tie between the clinical outcome and the patient reported outcome, and I'm not sure that we know what that is, but in terms of measurements it would seem to me to at least be important to be aware of that and to perhaps even intentionally pursue that so that, again, kind of in the future we're led to better and better kinds of measurements.

Robert McClure – Chief Medical Officer - Apelon, Inc.

This is Rob; I need to get regrounded on what we want this group's goal is? So, there is...in order to kind of get from end-to-end obviously part of this is deciding whether measures are good and I don't think that's the role of this group. I think there are, in fact I don't think, I know, that NQF is in the US currently charged with doing that work, deciding whether a measure is validated, achieves its end point, you know, it's stated goals, is crafted well and all of those sorts of things.

And my understanding of what we're asked to do is to try and figure out whether a measure, you know, that's presented has certain characteristics that would suit it to being an e-Measure and granted that is hard and its gets tied up into the same sort of things that, you know, an organization like NQF would have to deal with, but I don't think they're the same thing. And so in part, we also have to decide, you know, what are those things that have to be in the EHR? And so part of that is trying to get a sense of whether the...you know, is the measure asking that certain things actually get documented and therefore when the measure is evaluated you see parts of care or whether the measure, in terms of, again now I'm really focusing on this nuance thing that I think our responsibility is which is what makes it possible to do this as an e-Measure.

And, so sometimes it's about can you record the things that the measure needs because the measures intent is to identify elements of care. Other times the intent of the measure, particularly under the lens of an e-Measure analysis is to assess whether the measure activity was done not so much to identify and record specific attributes of care that as a clinician I think about like, you know, recording things that I need as a clinician to take care of the patient versus recording things that are only really useful in the analysis of the...well I'll say is a process, in other words the fact that they actually did these things that I think are important in order to, you know, as a quality assessor, in order to be able to assess quality.

So, there are a lot of subtly that I'm trying to get at here, but I worry that, I mean, you know, there's a lot of difficult work that has to occur in order to assess whether a particular measure has value and that's not our job.

Karen Kmetik – American Medical Association

So, Rob, this is Karen, just let me jump in and say I'm confirming what you're saying, correct we are not evaluating the value of a measure, but we're saying that others, we may be part of that conversation will say that there are process measures that are very important and they're going to want to put them forward. There are delta measures that are important, they're going to want to put them forward. There are outcome measures or patient reported outcome measures. So, if we assume somebody has said that this kind of measure is of great value then yes we're charged with, well what do we want to ask, know, learn about whether this measure is good, ready, what needs to happen to make it ready to be reported, I guess, well I'm not sure what the word is, to be integrated, to be applied.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Encoded, well encoded actually I shouldn't...but retooled to use Floyd's word as an e-Measure, right? So, can this be retooled?

Karen Kmetik – American Medical Association

I would say we'd like to make a point where we're designing the measure from the beginning to be used in an EHR so we're not really retooling anything. We're designing a measure for EHR platform.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Right, right.

Karen Kmetik – American Medical Association

Okay.

Robert McClure – Chief Medical Officer - Apelon, Inc.

And I can't remember who spoke earlier that said they weren't sure, and I fall into the same category, that when we think about this through a lens it's just about whether this measure that's being proposed would work well in the context of an e-Measure. I'm not sure that I can say that there's another column, for example, in your slide that needs to be there and even within any column that there is some unique attribute of that measure that's different from process measures that we would need to apply in an outcome measure, because in the context of what we're looking at, in a somewhat generic way, it's the same sort of thing.

In other words, can this be...you know, is it disruptive or not within the process of delivery of care which is an element of the usability. You know, feasibility is somewhat similar but it's the same sort of thing. In other words, if someone proposes an outcome measure separate, you know, from this issue of whether it's a good measure, it does boil down to, you know, is it feasible to record accurately what that measure actually looks to do and that's just the same as a process measure.

And, so I'll be honest, focus just with our lens and with not a lot of research, you know, both in terms of thinking about it and also having read any research about this. I'm not sure that there are other metrics about outcome measures that make them distinct in answering this question.

Eric Rose – Intelligent Medical Objects

This is Eric Rose; I was the one who had made that initial comment and I think actually the discussion of, I would call them patient centered outcome measures not necessarily patient reported, because they can be reported by anyone, but the discussion of patient centered outcome measures I think is actually relevant to our work, it hadn't occurred to me, but the...you know, patient centered outcome measures are what the patient wants from their perspective and the thing about that is that they're going to be unique for each patient and that implies unique demands on an information system.

If I want to record that the patient's goal is to, you know, be able to walk to church and back without assistance or, you know, be able to live long enough to go to his daughter's wedding or what have you, those are things that are...in order to be able to record and track those you would need your EHR to be able to allow essentially, a customer isn't really the right word, but a user fill in the blank data element and many EHRs have those, but not necessarily the ability to make that part of a quality measure.

So, I think that there is something worth exploring there and it may be that we want to at least say that for patient centered outcome measures we need to explore the idea of data elements that reflect patient expressed goals of care.

Robert McClure – Chief Medical Officer - Apelon, Inc.

So, if I could jump in, because Eric, you're right and I thought about that and it maybe more evident in an outcome measure, because what I think you're saying is, is that for these kinds of measures where the patient is an integral part of the data collection process, that the EHR has to support that, has to support the ability for the patient to actually enter data in a way that then a quality process can abstract, you know, can grab it and include it in its report.

Eric Rose – Intelligent Medical Objects

Well, it might just be verbal communication, the patient doesn't have to physically enter the data, but the critical thing is that the patient is the one who defines what the desired outcome is and then in the process of, you know, interpersonal negotiation with their provider discusses whether it's feasible or not, okay that's our goal, we're going to shoot for that kind of thing and that, you know, happens in health care every day, it doesn't necessarily get recorded in EHRs as discrete data.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Well, I agree, but again I'm not sure that that's distinct from some of our other things. I mean, we talk to patients all the time and, you know, negotiate an outcome or an activity, a process that we expect them to do and then record it, and you know, the fact that the patient may actually be the one who accurately represents that piece of information I think is somewhat unique.

Eric Rose – Intelligent Medical Objects

Right.

Robert McClure – Chief Medical Officer - Apelon, Inc.

And it may be more often in these kinds of measures, but you know, it isn't, I don't think substantially different from what might occur in any other process measure, but it is I think important to capture that. One of the things that this means is something that we've also seen elsewhere and that is that you have to have a way...an EHR has to have a way of being able to say whose the source of something, because that's important in these kinds of measures and you have to be able to, you know, differentiate among whether a source and then a recorder are, you know, represent different people, because again we've seen in quality measures that those are important elements.

Gene Nelson – Dartmouth University

Hi, this is Gene Nelson, I'm not on the committee but I think I was invited to join this call, is that correct, Karen?

Karen Kmetik – American Medical Association

Absolutely.

Gene Nelson – Dartmouth University

A couple of comments, of course it's a complicated topic and many facets to it. One issue, in terms of clarity is there are outcomes of care and there are health outcomes and all outcomes of care might not be health outcomes, and sometimes that can get blurred. So, for example, the re-admission maybe a health related outcome but in and of itself re-admissions aren't a health outcome, as we know a person coming to an ED in one ED may be re-admitted and the same person in another ED will be sent home for home care. So, it's a health related outcome usually related to health status, but it's not really a direct health outcome.

And then another issue, that I think Eric was just bringing up that, the term patient centered outcomes could be patient centered and preference-based. So, I want to be able to walk up the bleachers at Red Sox Stadium to see the 4th of July game, so it's mobility plus my preference for mobility or it may simply be the health state of mobility. So, the person's preference is important of course and it's related to different health states like mobility or cognition, or mental health, but again they are not identical. So, some things to keep in mind in terms of the terminology that we're using.

Karen Kmetik – American Medical Association

Thanks, Gene, that's helpful.

Robert McClure – Chief Medical Officer - Apelon, Inc.

So, my take on that is that one of the things, particularly around this patient centered aspect, is that it does have an impact on terminology and if, you know, if we're making rules about whether things, you know, fit in the bucket or don't it's likely that outcome measures, particularly patient centered outcome measures, will have substantial demands on terminology such that you probably will not be able to standardize that. It will require some kind of, you know, a kind of I'll say a summarization of meaning that may in fact be standardized, but the specifics that are important for a particular patient are never going to be standardized or very rarely.

So, the example that was just given is a good example of that, where it maybe that a measure says, okay you want to define a measure for the patient, that's what's important, you know, the fact that it's a mobility measure versus a, you know, a change in habit, outcome or something else is less important and so

there has got to be a way of standardizing the fact that there is, as a goal, that's a standardized way of representing a goal, like the example that there was a mobility goal or a, you know, I don't know what you'd call it, but like "I want to stop smoking" or "I want to stop drinking" or something like that. There is some way of standardizing that, but the specific one is not probably going to be standardized, so we have to...I think we would allow for measures that support a core aspect of that to be standardized but we wouldn't, I think, worry about the fact that many measures are going to require very unique statements that aren't going to be standardized.

Eva Powell – National Partnership for Women & Families

Yeah, and this is Eva, I think that's true but I think one way around that or to deal with that from a standardization point is kind of what Karen had suggested earlier about creating some sort of measure about whether or not a goal was made and met and that way you don't have to standardize the specific goal, but the technology can be used to essentially reconcile one element of the record to another and if it's reconciled then that means that the goal is met, if it's not then the goal is not met and understanding why, but I agree, I think this is a really difficult thing to allow for patient differences and yet still get at patient experience and patient outcomes that obviously are going to be very unique to the individual while still standardizing that in a fashion that can allow us to use it for measurement.

But the other thing, and I don't know where this fits, perhaps it fits under the column of feasibility but a lot of what we've been talking about strikes me as we're putting a lot of pressure on the EHR, which obviously is the central technology for Meaningful Use, but I think a lot of what the measurement in the future is going to require is the ability to pull data from multiple data sources and right now that is something we don't...at least to my knowledge, there is not the capacity for, and I don't know if that's something we need to somehow explicitly state and if so where do we put it or if that's a new column or what.

Karen Kmetik – American Medical Association

Right. So, I know for example I get lots of e-mails from my large provider group that ask about mostly my experience of care but they equally could, through that route, send me questions about post surgery.

Eva Powell – National Partnership for Women & Families

Right, I mean that would seem to me a perfect way to get patient outcome data, because obviously as was said, we need to build in various ways of collecting that, but ultimately the patient needs to be the source, the patient and/or caregiver and I think we need to be really careful about providers or other members of the healthcare team recording responses for patients, unless there simply is no other way to get that, because there is just interpretation and recording error and all of that, but if it's really coming from the patient we should use technology to make sure that that can happen.

Karen Kmetik – American Medical Association

Right, I'm just wondering...do people have experience where that information comes directly from the patient perhaps through some web portal, but some aspect of the results, what the patient says, summary score, something, is then added to the EHR record.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

This is Rosemary, just to answer that question with the EHRs that I've had experience with the patient's goal can be structured and stored and it's different than the outcome, because the goal is what you expect and the outcome is what actually occurred. In EHRs most of that on the acute care side would come from the clinician entering it in but then they specify that it's patient reported or that's what the patient wants in terms of a goal.

So, the EHR can store it, personal health records can store it and home care systems can store it, but they tend not to interoperate with each other, so, it doesn't follow across the continuum if you will, but most of the inpatient records and the home care systems have the ability to store what is called a plan of care that has the problems, all the activities and orders, and services related to the problem, goals and outcomes and through responsible parties and drop downs can specify whether it's a goal that the clinical

team desires for the patient or it's one that the patient reports themselves, like they want to post surgery go back to work in 6 weeks or whatever and they kind of do that through responsible parties and specify that, but that information tends to sit within this separate system and does not interoperate between systems.

At this point in time tends to be non-medical members of the team, I don't want to say that exclusively, that interoperate with this entity called a plan of care. Does it have a specific definition? I do know that HL7 Patient Care Committee is looking at it to define it from a terminology perspective and most of the EHRs have some capacity to support capturing it.

Karen Kmetik – American Medical Association

Thanks Rosemary, so that leads me to say I think we'd have to be careful on a patient reported outcome of care, I'm using Gene's terminology correctly, I'm not sure we'd be requiring a place to record the results in the EHR.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

That would be difficult.

Karen Kmetik – American Medical Association

Go ahead.

Eva Powell – National Partnership for Women & Families

Karen, this is Eva, I just...I'm wondering what your thought is about how do we get at this issue of, as Rosemary put it, interoperability where information that's recorded in one place that's really vital for a particular quality measure, but needs to be combined with other pieces that are in other places, whose role is it to get at the nitty-gritty details of what we need to do to make that happen? Because while it may not be...we may figure out at some point that it's better to record these things in a place other than the EHR, we still need to get the results and somehow enable the use of data from multiple sources for a single quality metric.

Gene Nelson – Dartmouth University

This is Gene; Again, I think that this issue of being able to track let's say the status of patient over time and across settings, the health status or the evolving health outcomes is central and will be central, so by analogy, just as we would wish to be able let's say to track a person's blood pressure level across time and over settings or their blood sugar level across time and over settings, for the same reasons we wish to be able to track a person's pain level for a specific problem or their depression level over time and across settings, and some of those reports come from diagnostic tests like blood sugar or from a clinical measurement such as blood pressure and some come from a patient report such as level of pain, back pain or responses to a standard questionnaire about depression symptoms which enables us to grade level of depression just like we in essence grade blood pressure so that we would like to have the ability to track these kinds of health states, health outcomes be they patient reported or diagnostic test reported across time and over settings hence interoperable.

Eric Rose – Intelligent Medical Objects

This is Eric, you know, there's something about that that concerns me a little bit in as much as the directive for this Tiger Team is I think to try to establish the boundaries for...the sort of technical boundaries for a good or acceptable clinical quality measure given the realities of clinical care and HIT today. The idea of ad mixing data among different care settings is one that I think holds a lot of promise and it also holds a lot of risk and I think it actually would be worth our time to articulate back to the larger committee that that needs to be approached with a lot of caution.

So, a quality measure that requires for instance that a patient's weight be the patient's weight from a lot of different sources be included in, you know, whatever the clinician refuses, something to that effect, is perilous, because, as you well know from one scale to another and in any given doctor's office you may have differences in weight, the same goes for measurements of blood pressure, the same goes for

standardized symptom scales, you know, that are arrived at by interpersonal interview, there are a lot...I mean, almost anything other than a lab test is subject to change. So, that doesn't necessarily mean that you don't mix the data obviously, you don't take into account data from different care settings, but the risk needs to be acknowledged and that needs to be approached with a lot of caution I think.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

This is Rosemary, just to add to that caution area there is quite a bit of contextual information, you know, related to patient's preferences and their characteristics that are very important but probably at this point in time maybe lack the standardization necessary to support it. So, although goals could be structured there is all this contextual information, it's very important in order to interpret it, to analyze it, to make decisions and that maybe another area of caution in terms of that contextual information.

Karen Kmetik – American Medical Association

So what I'm...Karen, if I can try to pull all the thoughts together, what I'm hearing is both for outcomes, whether we're talking about, I think in most cases here we're talking about outcomes of care not that we wouldn't at some point be interested in health outcomes as well, but as a first step I'm imaging the measures that will come through would be outcomes of care and you all can challenge me, so whether it's that or some patient reported, some patient preference information, we should apply the same filters we've applied to the process in delta measures, but we need to think about maybe adding a column in these two cases of some unique attributes, some cautions because even more so than in the other types of measures it's likely this information will come from somewhere else, from multiple places and somehow we need to take that into consideration. Is that...am I headed in the right direction?

M

I think so.

Eva Powell – National Partnership for Women & Families

Yeah, this is Eva, I think so too, but I think instead of caution you might term it issues to be resolved or something like that, because I guess I tend to think a little more futuristically in terms of what do we need the technology to do if we're going to have better quality metrics and particularly for things like care coordination there is a real paucity of metrics period and then when you put the caveat is they must be good there are even fewer and so...and a big reason for...there are lots of reasons for that, but I think a big reason for that is that we still have the mindset of a paper chart, one data source, but I don't see that we're ever going to have a great quality metrics for care coordination that doesn't use multiple data sources, because care coordination is not a solitary sport, it's a team sport and I just...I feel like we...and I don't know if our task is to look at the here and now and only say what we need to do now, but I was thinking that this group could also identify the things that need to happen in the future and perhaps for some of these things that we all see as being areas that could present problems, we need to call those out, but call those out as things that need to be worked on, that need to be resolved not so much as barriers.

Karen Kmetik – American Medical Association

No, good point, Eva, agree completely, it's a frame of mind, it's that we want to find the answers. So, I would say as an example, I think it was Rob, who said, we might say whereas in many of the process measures we feel pretty good about standard terminology being used, I mean, at least we can articulate the HIT recommended code sets, they may not all be used in the EHR, but we can head in that direction. For a patient reported outcome measure we are recognizing that we don't have the standard terminology for all of the elements of that. We might begin by trying to standardize the goals or some summary buckets, but to call out that that's work that would be needed if we think it's important to do more standard terminology, but not that it would mean we wouldn't want to move forward.

Eva Powell – National Partnership for Women & Families

Right and I think that it's also important to call out the need to...for both, both clinical outcomes and patient outcomes to always have this feedback loop to the clinician of how he or she is doing in the course of providing care, because certainly there are those instances where say the weight varies

according to where you take it and that kind of thing, in other cases it's critical to have that information transfer from one place to another only because of just the reality that healthcare is really a busy, to some degree unpredictable kind of setting of care and if you can get information from one place and have it available in another rather than having always to ask it the second time that's a really valuable thing and a good example of that...and it definitely has the potential to impact clinical outcomes. A great example of that is the patient preference of language.

If you're looking at a clinical outcome of, you know, whether it's meeting the clinical goals of care or, you know, just even say, you know, the diabetic having the goal of controlled HbA1c, there's a huge patient component to that, but if you're not collecting the fact that the patient does not speak English and needs to have a certain dialect of Spanish or even just plain Spanish, to be communicated with then that preference is going to likely lead to the downfall of your clinical goal and so it's going to be really important to be able to track, well, you know, when the person isn't able to be controlled, what is the reason for that? How can we make this better? And you've got to somehow be able to get to, ah maybe we should speak their language in terms of giving them their patient education and the materials they need at home to do what they need to do.

And so, I just think that those are the places where these two kinds of outcomes work very closely together and we've got to somehow be able to get to that and then get the summary information back to the clinician.

Eric Rose – Intelligent Medical Objects

This is Eric, I couldn't agree more and at the same time what you're describing really are process measures not outcome measures and you touched on two that are actually part of the proposed Stage 2 Meaningful Use objectives, you know, gathering demographics including patient's preferred language and sending or receiving summary of care records and transfers of care, but neither of those seem to describe outcomes. They contribute to outcomes, but...

Eva Powell – National Partnership for Women & Families

Yeah, well and I guess I'm thinking, again it's a tie between the process of outcomes that yes providing materials in those spoken language of the patient that's a process, but then that also leads to the patient outcome of experience here and if you're collecting experience of care as an outcome that's another source of information that can help point you to the reason for the non-ideal outcome that you may be getting clinically such as uncontrolled HbA1c. So, I think it's hard to discern in these places where there is a such a clear link between process and outcomes and honestly I think that's good, those are the processes that we need to be measuring rather than other processes that really don't have a clear bearing on those things, but I think there are places where these things can be looked to as outcomes.

Karen Kmetik – American Medical Association

This is Karen again, and it's making me...there is probably going to be over time best practices, leading practices, ways in which EHR vendors and providers have worked together to pull all that information together in a meaningful way that improves care delivery and I don't know that we can address all of that here. I think what we're, you know, going back to our charge is to say, someone comes forward and says here is an outcome of care measure that we want everybody to track and its related to data in the EHR or here's a patient reported, we want to be able to say, okay, great, we've all asked for those measures.

If we put on our technical lens we need to check a few boxes to feel like it's a good e-Measure and it's hard because we know they interrelate, we know all these things, but someday I would think ONC and CMS are going to say, all right is this measure EHR ready, and so I just want to bring us back to are there any other things that you think, I mean I've heard that it's not all that unique, when it's a clinical outcome of care or patient reported, but I just want to ask it again, is there anything that we want on our big master check sheet as well look at such a measure through a technical lens?

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

This is Jacob, I think Rosemary mentioned earlier that there are existing standards but not necessarily probably nomenclatures for all of the constituents of what patient reported measures might be, I don't think that the Red Sox game walking capability is on there, but there is a place for it to go in the EHR and if nomenclatures could be defined I actually don't think that that would be out of scope for this group to say would be appropriate.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Jacob, I'm not following exactly what it is that you're saying.

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

I'm saying so there is a structure, right? So, there are two pieces that you need, right? There is a structure and a nomenclature.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Yeah.

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

So, as Rosemary described in many systems currently there is a structure, which is the plan of care section of an EHR, that's a goal, right? So, whether you say it in patient centered terms or whether you say it in sort of healthcare system centered terms there is a place for that to exist in an EHR. What I'm not sure of is whether there is a vocabulary or I'm sorry, nomenclature to be consistent with my term, with which one would express all of the things that are being discussed. So, I would think that nomenclature would be a dependent component of what needs to happen. So, as we think about the, you know, what are the ideal characteristics, back to Karen's sort of redirecting question, I would think that nomenclature and a way to consistently describe something would be one of the core sort of gaps to fill, right?

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

This is Rosemary, there is nomenclature, if that's what you're referring to, Jacob, in SNOMED to express goals and outcomes and outcomes could be modeled a lot like observations and findings. I can't say and I don't know, maybe other people on the call do, if it's phrased using a patient terminology, you know, probably would need some mapping there, because, you know, the patients or a consumer, or a person could use their own terminology to express it, so that's one. But there is a structure; there is some sense of nomenclature that is currently being used. There is this question of relationships, because, you know, goals and outcomes don't typically sit out there free floating, they're tied to some problem, condition or phenomenon that's important and that gets fairly complicated if it needs to be tied to a problem or a condition, or an intervention, because then you get these linkages and you get going, which could be somewhat complex and just an area of caution.

Robert McClure – Chief Medical Officer - Apelon, Inc.

And so, that's what I was trying to kind of get to before when I said that the idea, I think, you know, what we would expect to be is that measures, outcome measures I think are more susceptible to this than any others, that's why it's worth pointing out in this context that may define outcomes using standardized terminology, but I think we wouldn't expect, in terms of our...you know, one of our, I think intended goals is to say whether things are, you know, good, a good measure we're using in an e-Measure environment or not and I think it would be the value isn't there to try and capture the details of every patient's goal, because there will be things like "I want to walk up the stairs at, you know, Fenway to see the jets go by on the 4th of July" but that is a mobility goal and being able to have a terminology a methodology that allows you to be able to capture those things and be able to summarize them, this could be called an assumption, that is, I think a requirement that we would expect that there be a tie-in for any outcome

measure to these kind of standardized representations of traditional goals that could be compared across any data collection environment.

Just like we also said that we believe they should support the ability to identify, you know, whose the author, you know, whose the source, because that's also important and actually as I've been sitting here there is another thing that I thought of that again, in the context of processes there, I don't know if we talked about it a lot, and I think it's also in plan outcomes, and that's sequence. This is probably even more important perhaps in process than it is in outcome, but it is a part of outcome in that it is actually a hard thing to capture, it's actually a hard thing to capture in the QDM for NQF measures too, but that one thing occurred after another thing, that's often times and important element of a quality assessment. And, again in terms kind of, you know, I don't want to use the word barrier, but, you know, in terms of aspects of the measures that we want to assess in order to decide is this good, is this one a good measure for an e-Measure, that's one that we may say, yes it needs to be able to support that or not because we don't have good ways to do it.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

This is Rosemary again, I think within EHRs for goals and outcomes expected target dates can be captured, you know.

Robert McClure – Chief Medical Officer - Apelon, Inc.

But that's not the same thing, Rosemary. You know, sequence and using date it's a good way to attempt to try and capture that, but it's not feasible some times.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

Sometimes it's not, I mean the whole...

Robert McClure – Chief Medical Officer - Apelon, Inc.

Because you don't capture the date not because if you had dates you couldn't do it, but if you don't get it.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

Yeah and, you know, this whole critical path and all the EHR support for that, that was kind of the way 10 years ago, it's technically I guess feasible, is it feasible within the workflow is probably another question, you know, for all the numbers of goals and outcomes that patients, you know, have there is probably a workflow and a practical feasibility to the workflow, but there are other sense of linkages between problems, orders and goals, and that was the linkage that I wanted to bring up before, because that's very complicated and very complex from both a technical and a process workflow perspective, because for certain conditions one may want to know what the goals and the outcomes are and from a quality perspective look at them and it requires defining linkages which can be very complex.

Karen Kmetik – American Medical Association

This is Karen. These last comments have been very helpful because I think we are starting to tease out, you know, things that we want to look for when we put our lens of for these types of measures not to say they're not surmountable but things we want to particularly look for such as what I've been hearing in the last conversation is, you know, is there a place to capture it, what is the nomenclature, we're not saying today everybody has to use a certain one, but are we moving toward a summary nomenclature.

Gene, I'd be curious to your comment on that if that is in line with the state of the art of patient reported information. Who is the source, yeah, there is much complexity around the timing, but the example I had given was how do we even know, was this information obtained pre and post surgery, so the connection to time. I'm starting to see a list here of things that we just want to populate into our grid of information we'd want to at least see as we look at the readiness of this kind of a measure for the EHR.

Eric Rose – Intelligent Medical Objects

This is Eric, I want to introduce a note of skepticism about the idea of a standardized nomenclature for patient defined goals and I say this working for a company that makes it's living off standardized nomenclatures, so this might be counterintuitive, but I think that it makes perfect sense to have a situation where we expect and measure clinicians to explore with their patients what the patients goals are for their care and for their health, absolutely and that is something that doctors should be held accountable to and actually that comes out to be really more of a process measure than an outcome measure, did you have a conversation with and document what the patient wants from their health. And that in turn could drive EHR certification requirements, you know, for every problem or the patient overall have the ability to capture as discrete, but maybe not coded data, the patient's goals for their health.

I'm not sure I agree though that it makes sense, that there's a lot of value in aggregating with assumption logic, you know, all the patient defined goals that have something to do with mobility, all the patient defined goals that have something to do with pain, all the patient...you know, in a given patient database and I think we need to be parsimonious about what we try to mandate coded data entry for and really restrict those mandates because they...to things that are really necessary to achieve important health goals for society at large, because that imposes a lot of burden on end-users in many cases.

Karen Kmetik – American Medical Association

Eric, can I just ask you a follow-up question on that? So, I hear what you're saying about define goals, can you take that a step further, so if it was instead of piece of information that the patient is giving, like functional status, whatever it is mobility, how would you see that information being added to the EHR? What type of parameters would we look for or would say none?

Eric Rose – Intelligent Medical Objects

Well, there I think it's perfectly reasonable to seek, select and/or create a standardized nomenclature for those kinds of concepts that can be made consistent from one patient to another. How far can you walk without stopping to rest, you know, what's your pain on a scale of, you know, x to y, that sort of thing. But for the very personalized care goals what I'm saying is I think it's very reasonable for us to say EHRs need to be able to capture those, they need to be able to capture them as discrete data meaning you know whether it's there or not, but they don't need to be able to capture them as coded data meaning you can interpret the content of what's there in some kind of automated fashion so you know that, you know, be able to go, you know, climb up the bleachers at Fenway Park is a mobility goal.

Robert McClure – Chief Medical Officer - Apelon, Inc.

I have to say, Eric, I'm completely baffled by that, because the whole point is to be able to allow people to enter in information and say it's a kind of goal and then be able to track that in the context of an e-Measure, so how is it that what you just said would allow anyone to be able to then summarize and say that across, you know, your thousand diabetic patients who have a variety of goals that they've been meeting mobility goals?

Eric Rose – Intelligent Medical Objects

I don't think that individualized patient centered goals, I don't think that it's possible to do metrics, to do valid metrics on whether they're met or not, because if you do that then you're going to have just large scale gaming of the system. If I'm a physician and I'm on top of all the other regulatory burdens, I'm being told I've got to document patient centered goals and then record whether or not they were met, do you think I'm going to express those goals in a way that helps ensure that I can say they were met? I mean, you know, I think that we...

Robert McClure – Chief Medical Officer - Apelon, Inc.

Well there are a lot of attestations things in Meaningful Use measures; gosh I hope everybody doesn't have that same perspective.

Eva Powell – National Partnership for Women & Families

Well, and this is Eva, I think that's a critical place where it's the fox guarding the hen house in terms of the clinician being the recorder of all of this stuff, this is where it's critical to be able to use more than one data source and again, this is a place where patient contributed data is key.

Eric Rose – Intelligent Medical Objects

Absolutely.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Right.

Eva Powell – National Partnership for Women & Families

And if that patient contributed data is through a PHR then we need to be able to draw from the PHR as well as from the EHR.

Robert McClure – Chief Medical Officer - Apelon, Inc.

And also, let's remember this isn't about, you know, kind of some jailhouse test; this is about improving patient outcomes. So, you know, I'm sure there are a lot of physicians who are out there just to be able to game the system, they're humans just like all the rest of us, but there are actually a few that are interested in improving patient care and what we're trying to do is that they want to see in one place, particularly given what just said about the fact that I'd like to be able to have my patients record what they're doing and so I want to quickly be able to go some place and say how's the mobility of my diabetics doing? How's the mobility of my congestive heart patients doing? And I want to be able to do that quickly and if I can't do that in some kind of automated process I won't do it.

Eric Rose – Intelligent Medical Objects

I don't disagree, I think that you can standardize and measure outcomes of care including things that are patient centered like mobility or pain or degree of dyspnea or so on and so forth. What I'm saying though is that individualized goals of care, that you set up an inherent conflict when you say on the one hand record these in a way that's faithful to the patient's perspective and what they want, like "I want to lose 200 pounds" okay, on the one hand, and on the other hand say, okay, now we're going to keep track of or ask you doctor to keep track of how many patients are meeting their goals as defined by them and by the way we're going to publish that on, you know, hospitalcompare.gov or what have you.

I think that the first step is just to say, okay have the conversation, because a lot of the time, unfortunately when patients go see doctors they never get asked the question "what do you want out of your care, let's talk about the goals from your perspective" right? They're assumed a lot of the time and I think that's the whole idea of patient centered outcomes is to try to get past that and try to make the patient the focus of defining the goals of care, but if you simultaneously say, okay, now that's going to become essentially an ad hoc quality measure for every single patient, I think that the whole process will break down very quickly.

Gene Nelson – Dartmouth University

This is Gene; this is once again a really complicated situation. I wonder if we took as an example to sort some of these issues out, the annual wellness visit that is funded by Medicare and the annual wellness visit funded by Medicare includes the suggestion for patient reported information around things like depression and functional status and health risk behaviors, etcetera and then also calls for some physical examination, limited, very limited things like blood pressure and BMI, and out of that assessment that is part of the annual wellness visit that's let say a mix of patient reported and clinical examination findings comes a personalized plan of care and out of the personalized plan of care comes or attendant to that are preference-based patient centered goals, and so that's sort of the reality that we have right now that at the end of this process there is a personal prevention plan of care which would have very specific preference-based and patient centered goals that maybe hard to, as I think it was Eric that was saying, capture them discretely, yes, to then categorized them by type may or may not be difficult or valuable.

But then going upstream what's creating that personalized plan of care, there are the standardized assessments of functional status, symptoms and some clinical material. And we can, if that's discrete and coded in a certain way, we can determine if there is a change in the person's functional status or IADLs or ADLs, etcetera, as well as their blood pressure and BMI. So, we want our information environment to be able to intelligently use that information for a patient over time and then aggregate that up to clinical populations. So, our Medicare patients who have high blood pressure, what's the delta there or our Medicare patients who have depression what's the delta there, or our Medicare patients who have high BMI what's the delta there?

Karen Kmetik – American Medical Association

Gene, this is Karen, I found that very helpful and it almost takes us back to where we started by saying there are care goals or care plans, there is patient reported information that will help us assess whether that care goal is met, there's clinical outcome of care information that will help us assess whether that care goal is met, and I don't know today that we, in this Tiger Team, can figure out how best those should interact, but what we can do is maybe shine a light on the fact that those are three distinct but interrelated concepts, if they come forward as measures we need to ask the question is the information at least captured in a discrete way? After that we might ask, is it using standard nomenclature if it doesn't exist yet let's recognize that, but let's sort of be shining a light on it. Would others phrase this latest conversation differently?

M

No, I think that's good.

Karen Kmetik – American Medical Association

Very complex stuff, I think we all need a week retreat somewhere nice so we could figure this all out. Any other comments anyone wants to make right now? Very helpful everyone as always I learn so much on these calls from each of you who have such good insights and perspectives. I am going to take a shot at trying to put all your good suggestions to paper and as I said send that your way and give you at least a week to mull it over and let's have a dialog by e-mail please. So, I would ask MacKenzie, could we open up for public comment?

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Sure, operator can you please open the lines for public comment?

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comments at this time.

Karen Kmetik – American Medical Association

Thank you, then I'll just ask again, any other final comments?

Gene Nelson – Dartmouth University

This is Gene again, Karen, it might be helpful to use as a test for some of these conventions that we've been talking about to use something like the annual wellness visit because the Regs are there, health systems are trying to pay attention to it and it does have this mix of data sources and data uses that might be a case in point. There are many cases in point of course, but it maybe one case in point that can help us clarify some of these tangled issues.

Karen Kmetik – American Medical Association

Thanks, Gene, I'll take a look at that, I'm certainly familiar with the work and see if we can use it as an example at least. Any other thoughts? Thank you all so much, look forward to talking more by e-mail.

M

Thanks.

MacKenzie Robertson – Office of the National Coordinator

Thanks, everybody.

M

Take care.